Social and Behavior Change Communication Strategy for Nutrition

Zimbabwe, March 2021

GLOBAL NUTRITION CLUSTER
Technical Alliance

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Acknowledgement

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About the Global Nutrition Cluster Technical Alliance

The Global Nutrition Cluster (GNC) Technical Alliance (previously GTAM) is a common global mechanism endorsed by over 40 Global Nutrition Clusters. GNC partners provide systematic, predictable, timely and coordinated nutrition technical assistance in order to meet the nutrition rights and needs of people affected by and at risk of emergencies. It is led by the United Nations Children's Fund (UNICEF) with World Vision International (WVI) as co-lead. The Alliance Technical Support Team (TST), formerly known as Technical Rapid Response Team (Tech RRT), is led by International Medical Corps and funded by USAID/BHA, SIDA, Irish Aid, UNICEF and Save the Children. More information about the Alliance can be found here: ta.nutritioncluster.net.

Table of Contents

Social and Behavior Change Communication Strategy for Nutrition

Save The Children, Zimbabwe

I. Background

Save the Children is the world's leading independent organization for children. It is a dual mandate organization and focuses on development and emergency responses. Save the Children currently works in 120 countries around the world touching the lives of 125 million children. Our mission is to inspire breakthroughs in the way the world treats children, and to achieve immediate and lasting change in their lives. In East and Southern Africa region, Save the Children works in 12 countries delivering both humanitarian and developmental support. Within this region, Save the Children has identified community engagement and behavior change as one of the priority areas for the countries as it implements its 2019-2021 Country Strategic Plans (CSP). The importance of behavior change has even been more amplified by COVID -19, where community engagement and change in behavior related to hand wash and maintaining socio distance are pre-requisite to avoid corona virus transmission.

The Nutrition Social Behavior Change Communication (SBCC) mapping exercise conducted for the Save the Children 12 country offices revealed the need for designing SBCC strategies for strengthening the nutrition programs. Based on this need and request from Save The Children, Zimbabwe, the Global Nutrition Cluster Technical Alliance (GNC Technical Alliance) provided technical support in conducting formative research and developing an SBCC strategy for the nutrition programs in Zimbabwe. This SBCC strategy has been developed by the program team in Zimbabwe with support from the SBC Advisor, GNC Technical Alliance, Technical Support Team.

II. Situation Analysis

Zimbabwe continues to experience a large-scale humanitarian crisis due to man-made and natural hazards. Cyclone Idai, consecutive failed rainy seasons, droughts, floods, and other environmental effects, compounded by currency instability and an economic crisis, are impacting the most vulnerable. The country's inflation rate spiked to more than 200 per cent in recent months. Since August 2019, the poor rainy season and long-lasting drought have significantly reduced crop harvests and access to clean and safe water, resulting in internal displacement and limited household food stocks. These climate induced shocks have resulted in food insecurity, loss of livelihoods and lower-income levels. The prices of commodities have increased beyond the reach of most rural households, thereby limiting access to food (ZimVac, 2020). While the country is grappling with the climate induced shocks, the emergence of Covid-19 pandemic has further threatened an already critical and fragile food and nutrition security. As such, the nutrition status of children has deteriorated with global acute malnutrition prevalence increasing from 3.6 in 2019 to 3.8 per cent in 2020. Likewise, only 16% of children 6- 23 months consume at least 4 food groups while 19% of the children 6-23 months receive the recommended minimum meal frequency. The indicators for WASH also show a dire situation with 13 of 52 districts having more than 50% of their households practicing open defecation. Save the Children staff in Zimbabwe have observed that while Zimbabweans have knowledge on appropriate health and nutrition behaviors, most of the population don't practice these recommendations. This observation collaborates the Zimbabwe National Nutrition Strategy which identified addressing the following factors as key in improving nutrition status for the country.

a) Inadequate knowledge and practices regarding appropriate and healthy diets for children and adults, especially among mothers and caregivers of children in the first 1,000 days of their life.

b) Inadequate knowledge and practices in relation to water, sanitation, and hygiene (WASH) and other health seeking behaviors (such as immunization, family planning and malaria control), especially among mothers and caregivers of children under the age of five years

III. Overall Nutrition Program Goal

To increase access to life-saving treatment services for chronic and acutely malnourished children under five while protecting, promoting and supporting appropriate infant and young child feeding practices that optimize nutrition and health survival outcomes in emergencies and development settings.

IV. Strategy Development Process

An evidence based, participatory approach engaging staff from all three program districts (Chimanimani, Kariba and Binga) was adopted in developing the SBC strategy for Nutrition. However, there were limitations in terms of time available to conduct extensive formative research in all three districts. The strategy has hence been developed based on desk review of previous studies and Focus Group Discussions conducted with community health workers (CHWs) to draw on their knowledge and experience in the communities. This strategy is hence to be considered a live document to be updated as and when further qualitative studies are done in all three regions. Post that, periodic review of the strategies and action plan basis monitoring of the implementation is also recommended. The process of strategy development included the following steps:

- **Desk review of existing studies and documents**: The following documents were reviewed to identify existing information and gaps around key recommended nutrition behaviors:
    - Positive Deviance Inquiry for Binga And Kariba Districts
    - Assessment Report, Harare, October 2016,
    - Barrier Analysis in Binga and Kariba Districts
    - SBCC Strategy for GROWN project
    - Zimbabwe 2018 National Nutrition Survey
    - Nutrition Communication Strategy – Ministry of Health and Child Care (2016)
    - Zimbabwe Multiple Indicator Cluster Survey (MICS, 2019)
- **Focus Group Discussion with CHWs**: Based on the gaps identified in the desk review, a focus group discussion guide was developed to collate additional information as well as corroborate the information from the desk review. A small group of Nutrition Coordinators from two of the three districts (Chimanimani and Kariba) were oriented on the tool through an online session. The team then organized FGDs with the CHWs in both districts to collect the additional information.
- **Virtual SBCC Strategy and Action Plan Development workshop**: The workshop was organized over two days on 30th and 31st March 2021. Participants in the workshop included Managers, Coordinators and Nutrition Officers from the team at the national level and the program base areas. Inputs provided by the team during the workshop, have been collated to develop the SBCC strategy.

V. Formative research findings

The formative research used as the basis for key decisions in the SBCC strategy included a desk review of the documents mentioned above and the findings from the CHW FGDs. The findings from both, the desk review and the FGDs are described below.

Initiation of breastfeeding within an hour of birth: As per Zimbabwe MICS, 2019, 99 percent of most recent live-born children to women age 15-49 years with a live birth in the last two years were ever breastfed, 59 percent were breastfed within one hour of birth (63% in rural areas) and 94 percent were

breastfed within one day of birth. The Nutrition Communication Strategy, Ministry of Health and Child Care[1], quoting a study based on program reviews mentions that common barriers of optimal breastfeeding for 0-6 months as delayed initiation of breastfeeding which is attributed to knowledge gaps among health workers. Additional barriers mentioned in the strategy document include the perception that colostrum is dirty milk and the social acceptability of pre-lacteal feeds. Grandmothers/mothers-in-law, fathers and community members influence mothers in giving pre-lacteals and early introduction of complimentary foods and liquids. As per the CHWs from Chimanimani and Kariba, there is a perception that breast feeding in the first hour after birth is difficult because the mother will be in pain. A few mothers throw away colostrum saying its dirty milk and it makes the baby sick. It is also believed that colostrum is dirty milk so a baby gets pre-lacteal feeds until the mother starts producing mature milk after a few days.

Exclusive breastfeeding for six months: As per MICS, 42 percent of children 0-5 months were exclusively breastfed. Consultations revealed that lactating mothers practice mixed feeding with some reportedly starting when the child is 2 months old. Factors behind mixed feeding include:

- The social acceptability of mixed feeding especially where mothers in law and the general community encourage young mothers to practice mixed feeding;
- Perceptions that the mother did not have sufficient milk especially when the child cries a lot mothers felt it was because the milk would be inadequate for the child;
- Mixed messages from health workers where in some instances mothers reported health workers encouraging mixed feeding and in some instances mothers reported not receiving any guidance on exclusive breastfeeding;
- The positive effects of exclusive breastfeeding and the negative effects of mixed feeding are not well explained to mothers so that they understand why they are encouraged to adopt exclusive breast feeding over mixed feeding.
- Mixed messages on HIV and infant feeding sometimes entrench stigmatization and mothers are pressured to practice mixed feeding

Key enablers to exclusive breastfeeding were identified as health providers' support, breastfeeding as a social norm, maternal knowledge, and awareness of benefits of breastfeeding, social support, feeding sick children along with the social influence of family, health workers and community members. It was also observed that mothers who were attended by skilled health workers during delivery were significantly more likely to exclusively breastfeed their babies and that appropriate messages about breastfeeding were being delivered by ANC staff.

CHWs from Chimanimani reported that mothers feel exclusive breastfeeding is difficult because a child needs more than milk to grow when they get to 3 months and the child always cries if you don't feed them food. It is also believed that exclusive breastfeeding for 6 months is not good for a male child because by the time a child gets to three months the milk will no longer be enough. Hence complementary feeding starts early for some mothers because they claim that milk only is not enough for a 4-month old baby so they feed porridge with peanut butter once a day. Fathers believe a child should be fed solid foods at 2-3 months especially if it's a male child or if he/she cries a lot. Most mothers give their children boiled cooking oil with salt for colic. Mothers- in-law, church leaders and community midwives (nyamukuta) are the most important nutrition and health behavior influencers.

Continued breastfeeding for two years and beyond: As per the MICS, 2019, 83 percent of the mothers continued breastfeeding for a year and 13 percent continued breastfeeding up to 2 years (16% in rural, 6% in urban). As reported by the CHWs from Chimanimani and Kariba, most mothers felt breastfeeding up to 24 months is difficult because the child needs more milk, and the mother loses weight. Most mothers wean

[1] Ministry of Health and Child Care (MoHCC). 2016. Zimbabwe Nutrition Communication Strategy. Harare, Zimbabwe: MoHCC

their children before they reach 2 years citing that they cannot cope with house chores and going to the field and also breastfeeding a child. The common perception was that when a child is looking healthy there is no need to keep breastfeeding. Some mothers breastfeed for less than 2 years because they want to get pregnant with another child in that same period. Traditionally, it is also a norm that boys are not supposed to be breastfeed up to 2 years it is believed they will be weak sexually.

Complementary feeding: As per the national MICS, 2019, the proportion of children who received minimum dietary diversity was 17 percent, minimum meal frequency was 68 percent and minimum acceptable diet was only 11 percent. Percentage of children age 0-23 months fed with a bottle with a nipple was 24 percent (40% urban, 16.5% rural).

The Nutrition Communication Strategy states that the barriers noted on complementary feeding (6-23 months) include poor quality complimentary foods emerging from a general prevalence of limited knowledge and information on good quality complimentary feeding. This results in provision of bulky starches and relatively sub-standard foods. In addition, both parents and caregivers are often not capacitated to leverage locally available foods and existing family diets as means to improve complimentary feeding.

As per the positive deviance study done in Binga and Kariba districts, feeding frequency was similar with all households and the children were fed mostly starch and breastmilk. Positive Deviant (PD) families however reported giving the child at least one snack per day as opposed to none amongst NPD families. Vegetable consumption was more common amongst PD families while NPD families fed vegetables less often. All children below 3 years of age were supervised during meals but the difference was that PD families give children their own plate and note amount of food consumed per meal which the NPD families did not do. Active feeding was practiced by all families but NPD families fed only thin foods as well as milk in response to illness while PD families continued to give family foods albeit in smaller quantities. Children in PD families fed the child more times than the NPD families who fed the children during the family meal times. Positive deviant households were found to have access to a home garden and the children from these households consumed more vegetables than their counterparts from non-positive deviant households.

As per the Barrier Analysis in Binga and Kariba districts, common barriers to feeding the child in adequate quantity, quality and frequency included: fear of choking the child; not knowing that its right for the child; unavailability of complementary foods; non-Doer Mothers don't know if their children are susceptible to malnutrition. The perceived negative consequences included constipation, loss of appetite, child will choke, child eats less than he/she needs, damage to the child's gut, you will feel bad for failing to care for your child. Other barriers identified include inadequate money to buy foods – unemployment and lack of income hinders mothers to feed children diverse diets. There is a perception that diverse foods means more food, which leads to overfeeding and obesity and lack of decision making powers by mothers.
The Barrier Analysis also revealed barriers around involvement of fathers in feeding the child. The perception/concerns among fathers included: it may look like you are bewitched, you could be disrespected by your spouse and extended family and there was fear of being mocked by other men. The perceived disadvantages were that women will not know their place in the home and society, men will become weak, men's decisions will be challenged in future and everyone in the community disapproves of this behavior. The influencers identified were: Men (peers), Community Leaders, Religious Leaders

Health seeking behavior and feeding the child when sick: As per the MICS, 36 percent children were given more liquids when they had diarrhoea, 32 percent were given about the same amount and 12 percent were given much less than normal. About 30 percent children were given about the same amount of food, 30 percent were given somewhat less and 26 percent were given much less than when not sick. Parents/caregivers did not seek any treatment for around 59 percent of the children when they had diarrhoea; 33 percent sought treatment from public health facility.

The Positive Deviance Inquiry showed that both PD and NPD families displayed good skills with regard to noticing illness in the child (noticing increase in temperature, loose stools, vomiting, reduced playfulness etc). However NPD families could not explain how to prepare home remedies such as salt sugar solution and tended to reduce meal frequency and texture during illness. PD families were using mosquito nets while only one NPD family was using a mosquito net.

With regards to feeding the child when sick, the Barrier Analysis study showed that Non-doer's perceived that their baby when sick has no appetite, the available food is not palatable, the child vomits, child develops fever, child cries a lot. Non-doers felt that their children would develop malnutrition even if they gave small frequent meals during illness. The perceived disadvantages among non-Doer's were: child does not recover, it is more discomfort for the mother, the child has loss of appetite, the child vomits, mother develops stress, child resents/hates the mother. Key influencers identified were Village Health Workers, Traditional Leaders, and Nurses.

VI. SBCC Strategy for Nutrition

Human behavior can be defined as a person's observable patterns of actions in relation to their environment that produce measurable results. The results can be positive or negative. In the context of Save the Children's nutrition interventions, a wide range of behaviors have an impact on the causes and effects of undernutrition. This strategy focuses on the nutrition specific behaviors that have been included in ongoing nutrition programs.

The strategy components include prioritization of behaviors, behavior change objectives, and overarching behavior change framework adapted from the Designing for Behavior Change (DBC) approach, key messages and an action plan for the identified SBCC activities. These elements are a description of the outputs of intensive group-work done by the participants during the strategy development workshop. As mentioned earlier, this strategy and action plan is a live document that would need to be reviewed and updated based on additional formative research and thereafter on a regular basis even during implementation of the strategy. The SBCC strategy development workshop agenda and group work outputs from the workshop are at Annexures I to V.

Key Principles

The five principles as outlined in the Designing for Behavior Change (DBC) approach, are very relevant for this strategy:

1. Action is what counts (not beliefs or knowledge).
2. Know exactly who your Priority Group is and look at everything from its point of view.
3. People take action when it benefits them; barriers keep people from acting.
4. All your Activities should maximize the most important benefits and minimize the most significant barriers.
5. Base decisions on evidence, not conjecture, and keep checking.

In addition to the above, the following principles would be vital to keep in mind for effective implementation of the strategy:

- **IYCF counselling:** A two-way conversation between a counsellor and mother/caregiver, based on a three-step process that includes assessment, analysis, and action to help the caregiver decide on what is best for themselves and their child in their situation. Counselling is different from education and messaging. Counselling is a way of working with people so that the counsellor understands their feelings and helps them to develop confidence and decide what to do.

- **Engage in dialogue**: ensure a two-way communication in all activities as it helps us understand what the people's information needs are, what they are concerned about so that we can share information that is relevant. It also helps build trust as people are able to express themselves and get information that they need.
- **Listen to the communities**: Listening to the community on a regular basis will help us understand what the drivers and barriers to adoption of the desired behaviors are. This information can then be used to adapt the key messages and solutions along the way, if necessary. It is important to remember that changing behavior is not easy for anyone.
- **Show empathy**: acknowledge the efforts and challenges and showing empathy towards them is especially important when working with pregnant women, lactating mothers. Empathy is the capacity to understand or feel what another person is experiencing from within their frame of reference, that is, the capacity to place oneself in another's position.
- **Build trust:** Most often, especially in times of crisis, people make decisions based on trust. Therefore, trust in individuals and organizations is the biggest factor in communicating with people. It is not enough to transmit a message; the person needs to accept it with full confidence.
- **Reiterate:** Behavior change can take time; you have to be patient. It is necessary to be persistent and **reiterate key messages**, using a mixed media approach that uses different channels of communication.

Priority Behaviors

Prioritization of behaviors was done basis discussions around five questions to establish the importance of the behaviors both from the public health perspective as well as program outcomes. The key determinants that influence the behavior and the feasibility of addressing the issue through SBCC were also considered. The following questions were included to aid prioritization:

- Is this behavior critical to improve health/well-being among target groups?
- Is it affecting program outcomes?
- Are most people not adopting this behavior currently?
- What are the main determinants for this behavior?
- Can the issue be addressed through SBC interventions?

Based on the number of positive responses to the questions, the behaviors were categorized into High, Medium and Low priority. While none of the behaviors were identified as low priority, the high and medium priority behaviors are:

High priority

- Mothers initiate breastfeeding within one hour of birth
- Mothers feed their babies only breastmilk from 0 – 6 months
- Initiation of complementary feeding at 6 months
- Parents/caregivers feed their babies (6 months and above) with solid/semi-solid foods in appropriate frequency, diversity and quantities
- Caregivers continue feeding in appropriate quantity and frequency even when the child is sick
- Fathers are involved in feeding the child

Medium priority behaviors

- Mothers/caregivers use a clean cup and spoon for feeding their child instead of bottle feeding
- Mothers continue breastfeeding along with complementary feeding till the child is at least 2 years old.
- Parents/caregivers seek timely treatment when their child is sick

The behavior change framework, message matrix and action plan have been currently developed for both, high priority behaviors and medium priority behaviors. However, as and when there is new formative research conducted for different other program areas, the findings would need to be considered and modifications included in the subsequent version of the strategy and the key messages.

Behavior change objectives

The objectives were developed by the team using a tool adapted from the Field Guide to Designing a Health Communication Strategy[2]. Based on the high priority behaviors identified, three broad objectives developed for the current version of the SBCC strategy are:

- Proportion of mothers who initiate breastfeeding within the 1st hour of birth increases from 60% to 75% in Chimanimani, Kariba and Binga districts by 2023
- Increase the proportion of Mothers feeding their children only breastmilk from birth to 6 months, from 40% to 60% in Binga Kariba and Chimanimani districts by 2023
- The proportion of parents/caregivers feeding their child (6-23 months) in appropriate frequency, quality and quantity increases from 11% to 30% in Chimanimani, Binga and Kariba districts by 2023.

Intended audiences

Social and behavior change communication interventions are more effective when they are targeted to specific audience groups as this helps in understanding their needs, barriers and enablers to behavior change. The intended audiences for SBCC consists of people who will directly benefit from the desired behavior changes and those who influence their behaviors. In this strategy, these groups have been called 'priority groups' or the primary audiences and influencers. The intended audiences for all high and medium priority behaviors were identified as part of the behavior change framework, as given below:

Behaviors	Priority groups
1. **Mothers initiate breastfeeding within one hour of birth**	**Primary Audience:** Pregnant women, Mothers who have just given birth **Influencers:** Nurses, CHWs, Spouses, Grandmothers /mothers-in-law, religious leaders, TBAs
2. **Mothers feed their babies only breastmilk from 0 to 6 months**	**Primary Audience:** Mothers of children 0-6 months old **Influencers:** Nurses, CHWs, Spouses, Grandmothers /mothers-in-law, religious leaders, TBAs, peers

[2] O'Sullivan, G.A., Yonkler, J.A., Morgan, W., and Merritt, A.P. A Field Guide to Designing a Health Communication Strategy, Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, March 2003

3. Parents/caregivers initiate feeding their babies with solid/semi-solid foods at 6 months	**Primary Audience:** Caregivers (mothers, fathers, grandmothers, older siblings) **Influencers:** CHWs, religious leaders, Nurses/mid-wives, TBAs, peers?
4. Parents/Caregivers feed the child (6 months onwards) in appropriate frequency, quality, and quantity	**Primary Audience:** Caregivers (mothers, fathers, grandmothers, older siblings) **Influencers:** CHWs, religious leaders, Nurses/mid-wives, TBAs
5. Caregivers continue feeding in appropriate quantity and frequency even when the child is sick	**Primary Audience:** Caregivers of children 0-23 months **Influencers:** CHWs, Traditional leaders/religious leaders, grandmothers/mothers-in law, fathers, nurses, medical health providers
6. Fathers are involved in feeding the child	**Primary Audience:** Fathers of children under two years **Influencers:** Peer groups of the target fathers, Mothers, Grandparents, Cultural leaders
7. Mothers/caregivers use a clean cup and spoon for feeding their child instead of bottle feeding	**Primary Audience:** Caregivers **Influencers:** CHWs, mid-wives, neighbours/friends
8. Mothers continue breastfeeding along with complementary feeding at least till the child is 2 years old	**Primary audience:** Mothers of children 0-23 months **Influencers** Mother-in-laws, spouses, CHWs, Religious leaders
9. Parents/caregivers seek timely treatment when their child is sick	**Primary Audience:** Caregivers of children 0-23 months **Influencers:** Traditional Healers, Nurses, medical health providers

Bridges to behavior change activities

The behavior change framework based on the DBC approach, includes identification of bridges to behavior change activities or bridges to activities, which are based on important formative research findings identified as barriers to change that need to be addressed. Bridges to behavior change activities are more specific descriptions of what one needs to do to address the issue revealed by the research. It proposes to change those perceptions of the priority group, which are critical for the behavior change to take place. The bridges to activities identified for each behavior are listed below. The practical application of these bridges would shape the way SBC activities are implemented. These have been considered while developing the action plan detailed in the subsequent section. To state an example, in order to reduce the perception that a mother will not be able to breastfeed within an hour of birth and that the colostrum is dirty milk, the ongoing activity of mother to mother support group weekly meetings could invite mothers or mothers-in-laws who have practiced or supported their daughter-in-law in feeding within one hour of birth, to share their experience and the benefits in a few meetings to initiate the discussion on the topic, discuss concerns of other mothers/pregnant women and address them. Doing this would help convince the mothers/grandmothers/mothers-in-laws and increase their perception that colostrum and initiation of breastfeeding within an hour of birth is important.

1. Barriers to initiation of breastfeeding within one hour of birth and colostrum feeding included the beliefs that breastfeeding in the first hour after birth is difficult because the mother will be in pain. A few mothers throw away colostrum saying its dirty milk and it makes the baby sick. Grandmothers/mothers-in-law, fathers and community members influence mothers in giving pre-lacteals. In order to address these, the bridges identified are to:

	• Increase perception that colostrum/first milk is healthy and boosts the child's immunity/ is healthy and beneficial for the child.
	• Reduce perception that the mother will not be able to breastfeed within one hour of birth.

2. The main barriers to exclusive breastfeeding were perceptions that the mother did not have sufficient milk especially when the child cries a lot, mothers felt it was because the milk would be inadequate for the child. There's also a belief that exclusive breastfeeding for 6 months is not good for a male child because by the time a child gets to three months the milk will no longer be enough. The social acceptability factor also needs to be addressed as mothers-in-law and the general community encourage young mothers to practice mixed feeding. The bridges to activities identified for this behavior are to:

	• Increase perception that mother's milk is all that every baby, both girls and boys, 0-6 months need to be healthy
	• Increase perception that breast milk contains sufficient water as per the needs of a baby 0-6 months old, even in hot climate
	• Increase the perception that with correct positioning and attachment, every mother produces sufficient milk for her baby, regardless of the size of the breast

3. Barriers to initiation of complementary feeding food at 6 months included the beliefs that Belief among mothers that a child needs more than milk to grow when they get to 3 months and the child always cries if you don't feed them food. Poor quality complimentary foods are being given to the children, emerging from a general prevalence of limited knowledge and information on good quality complimentary feeding. This results in provision of bulky starches and relatively sub-standard foods. In addition, both parents and caregivers are often not capacitated to leverage locally available foods and existing family diets as means to improve complimentary feeding. These would need to be addressed by:

	• Increase capacity/self-efficacy to leverage local available nutritious food
	• Increase knowledge on good quality locally available food for a child (6 months and above)

4. Key determinants to feeding the child (6 months onwards) in appropriate frequency, quality and quantity included that mothers don't know if their children are susceptible to malnutrition. The perceived negative consequences of complementary feeding were constipation, loss of appetite, child will choke, child eats less than he/she needs, damage to the child's gut and that as a mother you will feel bad for failing to care for your child. Inadequate money to buy foods – unemployment and lack of income hinders mothers to feed children diverse diets. Perception that diverse foods mean more food, which leads to overfeeding and obesity and no decision-making powers among mothers were other barriers

identified. It was also observed that children from households that had a home garden, consumed more vegetables than those who didn't have access to a home garden and families with well-nourished children gave a separate plate to the child to eat and checked the quantity being eaten. The bridges to activities identified for this behavior are:

	• Increase perception that diverse food does not mean more food
	• Increase perception that malnourishment can be prevented by feeding the child in adequate quantity, quality and frequency based on the child's age.
	• Increase knowledge of the signs, symptoms and causes of malnutrition
	• Increase knowledge on the age specific requirements for feeding the child (quality, quantity and frequency)

5. The barriers and determinants identified for continuing feeding in appropriate quantity and frequency even when the child is sick included perceived negative consequences such as the available food is not palatable; child vomits; child develops fever; child cries a lot. Some mothers fear that the child would resent/hate the mother. Some families could not explain how to prepare home remedies such as salt sugar solution and tended to reduce meal frequency and texture during illness of the child.

	• Increase perception that feeding a child while they are sick will help them recover quickly
	• Increase perception that feeding the baby when they are sick is not harmful for them
	• Increase knowledge around home remedies such as salt sugar solution
	• Increase knowledge around how and what to feed a sick child

6. Several barriers were considered important to address for the behavior of fathers feeding their child. Main concerns of men in being involved in feeding the child are: "it may look like you are bewitched", being disrespected by your spouse and extended family, fear of being mocked by other men. The perceived disadvantages are women will not know their place in the home and society, men will become weak, men's decisions will be challenged in future and the perceived norm that everyone in the community disapproves of this behavior. Bridges to activities identified to address these are to:

	• Increase perception among fathers and community leaders that fathers who feed their children are more caring fathers
	• Increase perception among community members that it is an equal responsibility of fathers and mothers to feed the child
	• Increase perception that the father and mother have equal responsibilities on all household chores
	• Increase perception of the value of shared decision making by mother and father on the welfare of the child

7. The behavior that mothers/caregivers use a clean cup and spoon for feeding their child instead of bottle-feeding included barriers such as the perception that bottle feeding is seen as a status symbol, ease of use such as when mothers are busy, they can give the child a bottle and continue with their work, hence bottle feeding is easier for the mother than using a cup and spoon. One of the reasons for this was also that mothers have high workload and very little support from the family on household chores. An enabler identified was that the cup and spoon is easily available at home and there is no need to buy special utensils for the child and that the cup and spoon are easier to wash and clean. Bridges to activities identified were:

	• Increasing perception that feeding with a cup and spoon has more advantages than bottle feeding
	• Increasing perception that mothers who use cup and spoon to feed the child, have healthier babies/care for the health of their child.
	• Increase knowledge on the advantages and ease of use of cup and spoon for feeding the baby

8. For the behavior of mothers continuing breastfeeding along with complementary feeding at least till the child is 2 years old, the main barriers considered were that mothers believe that breastfeeding up to 24 months is difficult because the child needs more milk and the mother loses weight. Most mothers wean their children before they reach 2 years citing that they cannot cope with house chores and going to the field and also breastfeed a child. Some mothers breastfeed for less than 2 years because they want to get pregnant with another child in that same period. Other barriers identified were the belief that traditionally boys are not supposed to be breastfeed up to 2 years; it is believed they will be weak sexually and that when a child is looking healthy there is no need to keep breastfeeding. The bridges to activities identified for this behavior are:

	• Increasing the perception that breastfeeding at least up to 2 years and beyond is not difficult and the mother will be able to produce the milk required for that age.
	• Increase the perception that breastfeeding can continue while one is pregnant without harming the unborn child.
	• Increase the perception that both boys and girls who are breastfed till two years, along with complementary feeding, are healthier/grow up to be healthier individuals

9. Barriers identified for the behavior that parents/caregivers seek timely treatment when their child is sick included religious beliefs prohibiting seeking of medical treatment - churches will give holy water which people believe is enough to recover, no medication required. Practical difficulties exist such as the need to walk long distances to reach health facilities, so they mostly don't take the child to the health facility unless she/he is very sick. It was also observed that people do not prioritize health within the resources that they have and that traditional healers are within the community hence easier to reach. The bridges to activities identified for this behavior are:

	• Increase perception that seeking timely treatment at the health facility when the child is sick has many advantages in terms of the skilled support and services that can be provided by the trained health personnel.
	• Increase perception on the importance of seeking timely treatment in terms of the health of the child/to ensure that the child recovers quickly.
	• Increase knowledge on signs and symptoms that will help in assessing the right time to seek treatment at the health facility.

SBCC Activities

Potential activities to achieve the bridges to behavior change were deliberated and included in the behavior change framework. These have been further detailed in the action plan to identify ongoing program activities within which the activities could be included as well as areas of integration with other sectors. The activities recommended as part of the action plan are summarized below:

- **One on one Counselling:** MIYCN Counsellors and Community Nutrition Workers (CNWs) at the facility level and trained Community Nutrition Volunteers (CNVs) along with lead mothers from MTMSG could provide counselling to the identified audience groups at the community level. For example, pregnant women in their last trimester and their influencers would be counselled on initiation of breastfeeding within an hour of birth. One on one counselling has been identified as especially important for appropriate attachment and positioning during breastfeeding. MIYCN Counsellors could also undertake outreach visits to counsel and motivate mothers of children 0-6 months of age for exclusive breastfeeding, undertake early risk assessment related to breast conditions and counsel mothers who have difficulties in breastfeeding or complementary feeding. This activity could also leverage health sector activities such as counselling on breastfeeding for pregnant women during their visits for ANC and adding emphasis on these behaviors during trainings of mid-wives and doctors.
- **Weekly sessions of mother-to-mother support groups (MTMSG):** All priority behaviors can be covered in phases in these meetings. The sessions will need to be made engaging through interactive games, stories, etc. followed by discussions. MTMSG members could also be motivated to organize other activities such as cooking demonstrations, healthy baby competitions. Positive deviant mothers could be invited to share their experiences during the sessions for initiation of breastfeeding within one hour, exclusive breastfeeding for six months and complementary feeding in the recommended frequency, quality and quantity from six months along with continued breastfeeding (depending on the topic being discussed in a session). The members could discuss, share experiences around breastfeeding both girls and boys for 2 years or more, can include fathers who may have been breastfed for 2 years or more to address the misconceptions that prevent mothers from breastfeeding boys up to 2 years. The meetings could be used as platforms for sharing experiences on how to feed/care for their child when they are sick, including demonstration sessions on how to prepare home remedies. Integration with other sectors could include WASH (MTMSG members participating in Water management committees or inviting members from the committee to MTMSG meetings to engage with the fathers), Health sector (MTMSG members to co-facilitate sessions at the facility level during visits by caregivers at facilities for ANC/PNC and child immunization).
- **Training of Lead Mothers:** While the training of Lead Mothers is also an ongoing activity on all recommended behaviors, the need for tailormade lessons on the importance of diverse food, age specific requirements for quality, quantity and frequency, essentially a lesson on healthy plate was identified.

- **Health Worker Mentorship:** This is an ongoing activity at the health centre implemented on a quarterly basis. The activity could include a special session around successes and challenges in initiating breastfeeding within an hour of birth. The Community Nutrition/MIYCN Officer at the facility level could provide support in developing the session. While the behavior change framework and action plan mentions this for one behavior, the feasibility and relevance to include sessions for other behaviors could also be explored.

- **Group sensitization sessions:** Sensitization sessions would need to be planned with the priority groups identified for each behavior, for example, sensitization on early initiation of breastfeeding will be done in separate groups with pregnant women, grandmothers and husbands. The sessions at health facility could include the topic of seeking timely treatment when their child is sick and motivate parents/caregivers to share their experience with others in the community. Ongoing program activities such as TSFP screening and distribution of supplies could also be used as platforms to conduct group sensitizations sessions. Other sector platforms such as FSL (Biometric food distribution, food for assets), WASH (Boreholes, distribution of WASH kits), Health (ANC and Growth monitoring visits), VSL (Village Saving and Lending groups) and Education (in schools with students, teachers and at parent teacher association meetings) could also be leveraged to conduct sensitization sessions.

- **Health workers training on conducting interactive sessions:** It has been observed by the program staff that the group counselling sessions held at the facility level are more of one-way communication by the health workers on the identified topics. It is hence recommended that the health workers should be trained on facilitation skills to ensure there is two-way communication so as to make the sessions more effective. Community Nutrition/MIYCN Officer at the facility level could train the health workers either in special trainings organized for this or included in relevant ongoing trainings of health workers in collaboration with the health sector.

- **Radio programs:** Three types of activities are recommended for radio: 1) a series of talk shows covering different topics with a panel comprising nutrition experts (MIYCN Counsellor, government officials), lead mothers from MTMSG, Community/Religious Leaders, positive deviants/role models especially fathers 2) a radio drama series especially focused on gender aspects of feeding behaviors could be planned with an entertainment education approach and 2) short 30 second to one-minute spots that can be aired on popular programs during commercial breaks. Collaboration with the Ministry of Health for free airtime for some of the talk shows could be explored. The activities, especially radio talk shows and drama series could be made interactive by encouraging audiences to call in with their questions and by organizing group listening (e.g. by MTMSG) sessions followed by discussions. All priority behaviors could be covered through these activities. Testimonials from fathers on their involvement in feeding the child (6-23 months) and on being breastfed for 2 years or more are behaviors identified for radio spots in the behavior change framework.

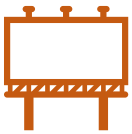
- **Cooking demonstrations/cooking competitions:** As mentioned earlier, this activity could be initiated by the Lead mothers from MTMSG. Positive deviant mothers (Hearth Model) could be identified, who would demonstrate preparation of complementary food for children 6 months and above, using the locally available foods. The recipes would be verified by experts for their nutrition value. The demonstrations could be used to promote timely initiation of complementary feeding, quality and diversity of food and feeding a sick child. Similarly, cooking competitions for preparing dishes using nutritious ingredients could be organized, where-in the judges would be children 6 months and above along with the adults (if the child likes the food cooked, that would be considered along with the nutrition value of the recipe). The recipes from the cooking demonstration as well as competitions could be collated to a cookbook on complementary feeding (which would have more visuals so that semi-literate

parents can also use). The activity can also be integrated with the FSL sector activities of promoting kitchen gardens and vegetable gardening.

- **Monthly meetings of Male Fora:** A group of Lead Fathers would be identified and trained on MIYCN promotion among fathers, by the technical staff along with MIYCN Counsellor. These trained Lead Fathers would then hold monthly group sessions with fathers, especially encouraging their involvement in child feeding, discuss the locally available foods and how to ensure access, such as kitchen gardens and what is feasible for them to do to support the family. Experiences from other countries[3] in engaging with fathers could be considered to develop trainings and session plans for the Lead fathers. Integration with other sectors would include with WASH (during distribution of NFI), FSL (kitchen gardens) and during general food distribution (GFD).

- **Development/modification of SBCC materials:** It is recommended that all existing material being used in the projects, could be reviewed from the perspective of the bridges to activities identified and key messages developed as part of this strategy. Based on the review, a decision could be taken on the need to modify or develop new materials that will be aligned to the strategy. This would include review and development of a reference guide for the health workers, in coordination with the MoH.

- **Other reminder channels and special events:** Posters, billboards, banners and other such channels/materials placed at strategic locations so that a maximum number of people can see them, could be used to reiterate and remind the audiences of key messages shared during the abovementioned activities. Health facilities, distribution points, marketplace and other places where people congregate would need to be identified to place these visual reminders. In addition, a series of activities to engage the communities could be organized on special days/weeks such as the World Breastfeeding week, Girl child Day, International Women's Day etc.



Key Messages and Materials

The messages developed for each behavior attempt to address either the barriers or enablers identified as part of the formative research. These have also been developed keeping in mind the bridges to activities and activities identified as part of the behavior change framework. While these are the core content for messages to be conveyed through different channels and activities, each message would need to be creatively tailored for different channels to make it attractive for the audiences. Technical content of the materials would need to be verified by experts for each material that is developed. Like the rest of the sections, this is not an exhaustive set of messages and would need to be reviewed periodically to add/modify the messages based on field requirements. The key messages and materials identified for each behavior are included in the table below.

[3] https://www.savethechildren.org/content/dam/global/reports/health-and-nutrition/real-fathers-initiative.PDF

Behavior	Priority Group	Barriers & Enablers	Key Messages	Materials/Channels
Mothers initiate breastfeeding within one hour of birth	Pregnant women, Mothers who have just given birth **Influencers:** Nurses, CHWs, Spouses, Grandmothers /mothers-in-law, religious leaders, TBAs	Belief that breastfeeding in the first hour after birth is difficult because the mother will be in pain. A few mothers throw away colostrum saying its dirty milk and it makes the baby sick	Early breastfeeding helps the baby learn to breastfeed while the breast is still soft, helps reduce your (the mother's) bleeding, and helps eject the placenta. It is a small effort that does not cause any additional discomfort for the mother, whereas the benefits are enormous for both mother and child. Colostrum is good for the baby as it helps protect your baby from illness/increases your baby's immunity which protects from diseases. Immediately after birth ensure skin to skin contact with the mother as this stimulates the child to start breastfeeding/suckling The more the baby suckles, the more breast milk is produced	Counselling cards including pictorial depiction of good positioning and attachment Radio talk show Posters (with prominent visuals to be placed in health facilities and clinics) Reference guide for the health worker
Mothers exclusively breastfeed their babies from 0 – 6 months	Mothers of children (0-6 months) **Influencers:** Nurses, CHWs, Spouses, Grandmothers /mothers-in-law, religious leaders	Perceptions that the mother did not have sufficient milk especially when the child cries a lot, mothers felt it was because the milk would be inadequate for the child Belief that exclusive breastfeeding for 6 months is not good for a male child because by the time a child gets to three months the milk will no longer be enough.	With good attachment and positioning, every mother produces sufficient milk required for the baby. Use local terms – the more you mwisa, the more you sisa Good attachment is when: • Your baby's chin is firmly touching your breast. • Your baby's mouth is wide open when suckling. • Your baby's cheeks stay rounded while suckling • Your baby rhythmically takes long sucks and swallows (it is normal for them to pause from time to time) All babies, whether girls or boys, need only breastmilk during the first 6 months of life as it provides all the food and water that your baby requires for proper growth and development. Giving your baby anything else will cause him/her to suckle less often and will reduce the amount of breastmilk that you produce	Counselling cards, Key messages for counsellors, Picture Story cards for MTMSG sessions Harmonized tally sheets for MTMSG (how many people reached with messages) across regions Banners, pictorials/posters (showing happy breastfeeding mothers and babies) Radio talk show/radio spots
Initiation of complementary feeding at 6 months	Caregivers (mothers, fathers, grandmothers, older siblings) **Influencers:** CHWs, religious leaders,	Belief among mothers that a child needs more than milk to grow when they get to 3 months and the child always cries if you don't feed them food Poor quality complimentary foods emerging from a general prevalence of limited	Along with breastfeeding, initiating complementary feeding for your baby only at 6 months, not earlier, increases protection for your baby from illnesses such as diarrhoea and pneumonia, and from malnutrition. When giving complementary foods, for adequate growth and development of your child, ensure: Frequency, Quantity, Thickness, Variety and	Banners for cooking demonstrations, Healthy Baby Competitions Recipe booklet for complementary feeding (with messages for quantity, quality and frequency of feeding as the child grows (6-8

	Nurses/mid-wives, TBAs	knowledge and information on good quality complimentary feeding. This results in provision of bulky starches and relatively sub-standard foods.	Active/ Responsive Feeding. (*could make an acronym in the local language)* • **Frequency:** Feed your baby complementary foods two times a day. • **Quantity:** Give two to three tablespoonfuls ('tastes') at each feed. • **Thickness:** Should be thick enough to be fed by hand. • **Variety:** Begin with the staple foods like porridge (corn, wheat, rice, millet, potatoes, sorghum), mashed banana, or mashed potato. • **Active/Responsive Feeding** - Baby may need time to get used to eating foods other than breastmilk. - Be patient and actively encourage your baby to eat. - Don't force your baby to eat. - Give your baby his/her own dish so that you can tell how much he or she is eating.	months, 9-12 months, 12 – 24 months) Specific materials for male forums – picture card on locally available nutritious food
Parents/Care givers feed the child (6 months onwards) in appropriate frequency, quality and quantity	Caregivers (mothers, fathers, grandmothers, older siblings) **Influencers:** CHWs, religious leaders, Nurses/mid-wives, TBAs	Children from households that had a home garden, consumed more vegetables than those who didn't have access to a home garden. Families with well-nourished children gave a separate plate to the child to eat and checked the quantity being eaten Mothers don't know if their children are susceptible to malnutrition Perceived negative consequences: Constipation, Loss of appetite, Child will choke, Child eats less than he/she needs, damage to the child's gut, You will feel bad for failing to care for your child	Continue breastfeeding your baby on demand both day and night. This will maintain her or his health and strength as breastmilk continues to be the most important part of your baby's diet. Feeding your baby in appropriate frequency, quality and quantity is necessary to prevent your child from becoming malnourished. **Frequency:** Start with 2 times a day in addition to breastfeeding and gradually increase to 3-4 times when the baby is 9 months old **Quality:** Give mashed/pureed family foods. By 8 months, your baby can begin eating finger foods. Try to ensure that each meal or during the course of the day, at least four food groups are included in the meals. (*Some places it is referred to as a 4-star meal – could use local expression that conveys – the best meal)* **Quantity:** From 2-3 tablespoons at 6 months, increase amount gradually to half (½) cup (250 ml-cup: show amount in locally available cup sizes). Use a separate plate/bowl to make sure your child eats all the food given.	Tailormade lessons for MTMSG meetings on the need for diverse food, age specific requirements for quality, quantity, and frequency - lesson on healthy plate. (Interactive, including games/stories/songs) Counselling cards Picture story cards for group sensitization sessions Radio talk show/spots Testimonials by positive deviant parents – audio or video
Mothers/care givers use a clean cup and spoon for feeding their child instead of bottle feeding	Caregivers **Influencers:** CHWs, mid-wives, neighbours/ friends	Bottle feeding seen as a status symbol. When mothers are busy, they can give the child a bottle and continue with their work. Bottle feeding is easier for the mother than using a cup and spoon.	Using a clean cup and spoon to feed your child has many advantages: - It reduces the chances of your child getting ill - From 6 months onwards, the child needs semi-solid or solid food to prevent malnutrition, which can easily be fed using a cup and spoon - A cup and spoon is available at home and there is no need to buy special utensils - They are easier to wash and much more hygienic	Posters, banners to be displayed during healthy baby competitions Cups and spoons branded with messaging for demonstration during MTMSG meetings (if feasible)

Mothers continue breastfeeding along with complementary feeding at least till the child is 2 years old.	Mothers of children 0-23 months **Influencers** Mother-in-laws, spouses, CHWs, Religious leaders	Mothers believe that breastfeeding up to 24 months is difficult because the child needs more milk and the mother loses weight. Most mothers wean their children before they reach 2 years citing that they cannot cope with house chores and going to the field and also breastfeed a child. Some mothers breastfeed for less than 2 years because they want to get pregnant with another child in that same period	Continuing breastfeeding at least till the child is two years old, will maintain her or his health and strength as breastmilk continues to be the most important part of your baby's diet. When your child starts complementary feeding, breastfeeding, it is possible for you to become pregnant again as it no longer prevents pregnancies. However, to help your baby continue to grow strong and give yourself time to regain your health, you should use a family planning method to prevent another pregnancy for at least 2 years. If you do become pregnant during this time, it is safe for you to continue to breastfeed.	Counselling cards, including messages on family planning/contraception Radio talk show including positive deviants as panelists Testimonials of fathers who have been breastfed for 2 or more years on radio spots,
Caregivers continue feeding in appropriate quantity and frequency even when the child is sick	Caregivers of children 0-23 months **Influencers:** CHWs, Traditional leaders/religious leaders, grand mothers/mothers-in law, fathers, nurses, medical health providers	Perceived negative consequences of feeding a sick child were: Baby has no appetite; the available food is not palatable; child vomits; child develops fever; child cries a lot. Some mothers fear that the child would resent/hate the mother	Breastfeed more frequently during illness, including diarrhoea, to help the baby fight sickness, reduce weight loss and recover more quickly. Breastfeeding also provides comfort to your sick baby. If your baby refuses to breastfeed, encourage your baby until he or she takes the breast again. If the baby is too weak to suckle, express breastmilk to give the baby. This will help you to keep up your milk supply and prevent breast difficulties. For babies who are 6 months and older, offer them simple foods like porridge and avoid spicy or fatty foods. Even if the child has diarrhoea, it is better for him or her to keep eating. After your baby has recovered, actively encourage her or him to eat one additional meal of solid food each day during the following two weeks. This will help your child regain the weight she or he has lost.	Visual materials (picture cards/leaflets) on caring for a sick child (separate for 0-6 months and 6 months onwards) including home remedies for the sick child Include topic in radio talk show
Fathers are involved in feeding the child	Fathers of children 6-23 months **Influencers:** Neighbours/friends, Other men, mothers-in-law, religious leaders	Main concerns of men in being involved in feeding the child are: It may look like you are bewitched, being disrespected by your spouse and extended family, fear of being mocked by other men Perceived disadvantages are: Women will not know their place in the home and society, men will become weak, men's decisions will be challenged in future,	A good father shares equal responsibility for his children's health and well being. Feeding the child is an important part of this responsibility. When a father takes up the responsibility of feeding the child, there is better emotional bond between him and the child. Ensuring appropriate quantity, frequency and quality of feeding for your child will make her or him both smart and healthy. This will increase the love and respect for you as the	Picture cards on locally available nutritious food types – for men's fora sessions. Counselling cards/picture story cards on IYCF Posters promoting male engagement in child feeding (showing proud, responsible, happy father)

		everyone in the community disapproves of this behavior	father, within the family and the community.	
Parents/caregivers seek timely treatment when their child is sick	Caregivers of children 0-23 months **Influencers:** Traditional Healers, Nurses, medical health providers	Religious beliefs prohibiting seeking of medical treatment – churches will give holy water which people believe is enough to recover, no medication required. Need to walk long distances to reach health facilities, so they mostly don't take the child to the health facility unless she/he is very sick	Recognizing the danger signs early and seeking timely treatment from the doctor at the health facility will help prevent the illness from becoming too severe to recover/will help save your child's life. Take your child immediately to a trained health worker or clinic if any of the following symptoms are present: • Refusal to feed and is very weak. • Vomiting (cannot keep anything down). • Diarrhoea (more than three loose stools a day for two days or more and/or blood in the stool, sunken eyes). • Convulsions (rapid and repeated contractions of the body, shaking). • The lower part of the chest sucks in when the child breathes in, or it looks as though the stomach is moving up and down (respiratory infection). • Fever (possible risk of malaria). • Malnutrition (loss of weight or swelling of the body)	Counselling cards on danger signs Leaflets with visuals on danger signs and when to contact the health worker/doctor

Action Plan

The activities included in the behavior change framework have been further detailed in action plan to assess other ongoing program activities within nutrition programs as well as other sectors that can be leveraged for each activity, the timeline or frequency of each activity, how would they be monitored and the internal or external support required (other than budgets). The timeline for activities has currently been presented as a frequency, which would subsequently need to be converted to a timeline when integrated with specific projects. The frequency of activities will also help in drawing up the budgets required to implement this strategy. As an overall timeline, as mentioned earlier, this SBCC strategy will be aligned to the Country Strategy for 2022 to 2023. The detailed action plan is attached as Annexure VI. However, in order to help develop an implementation plan for each year, the key activities are presented below as short term, medium term and long term. The timelines and responsibilities are representative and would need to be finalised based on feasibility for the team.

Sl. No	Activities	Sub-Activities	Timeline	Budget Required	Person Responsible	Supported By
Short Term: Strengthening ongoing activities in the first 6 months						
1	**Orientation on SBCC Strategy for key staff**	Develop presentation on the SBCC strategy for orientation of staff	Month 1	None	MIYCN Technical Manager	
		Orientation sessions for key staff in each region	Month 1	None	MIYCN Technical Manager	
2	**MTMSG weekly meetings**	Review training module for Lead mothers to include understanding the barriers, bridges to activities and key messages from the strategy	Month 1	None	MIYCN Technical Manager	Nutrition Manager/Coordinator
		Review and develop interactive sessions for weekly meetings based on the activity description and key messages in the strategy	Month 2	None	MIYCN Technical Manager	Nutrition Manager/Coordinator
		Developing and printing harmonized tally sheets for MTMSG	Months 2 and 3	Printing costs	MIYCN Technical Manager	Nutrition Manager/Coordinator
		Review existing materials being used by MTMSG based on key messages and checklist. Revise as required.	Month 2 and 3	Cost for revisions in designs, printing costs	MIYCN Counsellor	Nutrition Manager/Coordinator
		Training of Lead Mothers on the revised module (including basics of social and behavior change) and interactive sessions	Months 4 and 5	Training costs: venue, travel, equipment, food & beverages, facilitator travel	MIYCN Counsellor	Nutrition Coordinator/Officer
		Weekly meetings of MTMSG continue	Month 6 onwards	Incentives to Lead mothers	Nutrition Coordinators	Nutrition Officers
3	**Health Worker Mentorship - include a special session around successes and challenges in initiating breastfeeding**	Review existing format of Health Worker mentorship and identify the potential method to include the special session. Undertake a discussion with a few of the health workers to understand barriers around this behavior and incorporate potential solutions to	Month 1	None	Nutrition Manager	MIYCN Counsellor

	within an hour of birth	address them in the new session being developed.				
		Meetings with MoH to get buy-in for the new session	Month 1	Travel costs	Nutrition Manager	Nutrition Coordinator/Officer
		Introduce the new session facilitated by MIYCN Counsellor	Month 3 onwards, quarterly	Session facilitation costs: travel, equipment (if any), food & beverages	MIYCN Counsellor	
		Review of any existing Health worker guide/reference book on IYCF with MoH or other agencies based on key messages and bridges to activities in the strategy	Month 2	Internal review - no costs	MIYCN Counsellor	Nutrition Manager/Coordinator
		Incorporate revisions and printing of guide/reference book for Health Workers	Month 3 and 4	Design costs, printing costs	Nutrition Manager	Admin
4	**Group counseling sessions at facilities**	Develop training module on conducting interactive sessions	Month 2	Consultant costs (?)	MIYCN Counsellor	Nutrition Manager
		Health workers training on conducting interactive sessions	Month 3 and 4 (or align with ongoing trainings)	Training costs, travel costs	MIYCN Counsellor/Technical Manager	
5	**One-on-one Counselling**	Development/modification of counselling training module based on key messages and barriers to address as mentioned in the strategy document	Month 3	Consultant costs	MIYCN Counsellor/Technical Manager	
		Training of Community Nutrition Workers on revised module	Month 4 and 5	Training costs, travel costs	MIYCN Counsellor/Nutrition Manager	
		Training of Community Nutrition Volunteers on revised module	Month 4 and 5	Training costs, travel costs	MIYCN Counsellor/Nutrition Manager	

6	**SBCC material development**	Review of existing materials based on key messages, bridges to activities in the strategy and using a checklist	Month 2	Internal workshop costs	MIYCN Technical Manager	Nutrition Manager/Coordinators
		Revision of existing materials	Month 3	Design costs	Nutrition Manager	
		Development of new materials as per strategy document	Month 3	Design costs	MIYCN Technical Manager	MIYCN Counsellors
		Pre-test of all materials	Month 4	Consultant costs or FGDs/IDIs to be conducted by field staff - in which case, it would basically be the travel costs	Nutrition Manager	Nutrition Coordinators/Officers
		Revision and printing of materials	Month 5	Printing costs	Nutrition Manager	Admin
		Orientation on use of materials and distribution	Month 6	Transportation costs	Nutrition Coordinators	Nutrition officers
Medium Term: New Activities (months 7 to 12)						
7	**Cooking demonstrations with parents**	Develop criteria and identify Positive Deviants in each area (Hearth Model)	Month 7	Local travel costs		
		Collate and verify recipes with Nutrition experts	Month 7	None		
		Organize demonstrations followed by discussions with support from MTMSG members	Month 8 onwards (once in 2 months)	Event costs: ingredients, utensils/equipment, refreshments		
8	**Cooking competitions among MTMSG,**	Develop plan for competitions: criteria for awards, panel of judges, venue, awards etc.	Month 7	Internal: no cost		
		Oreintation of Lead Mothers to facilitate the competitions	Month 8	Training costs, travel costs		
		Conducting competitions in each area	Month 9 onwards (once in 3 months)	Event costs: ingredients, utensils/equipment, refreshments, awards		

9	**Healthy baby competitions**	Develop plan for competitions: criteria for awards, panel of judges, venue, awards etc.	Month 8	Internal		
		Oreintation of Lead Mothers to facilitate the competitions	Month 9	Training costs, travel costs		
		Conducting competitions in each area	Month 10 onwards (once in 3 months)	Event costs: ingredients, utensils/equipment, refreshments, awards		
11	**Radio Talk Show**	Planning: identify radio channel, number of talk shows, type of panelists, topics to be covered, schedule	Month 7	Internal: no cost		
		Finalize and sign contract with radio channel selected	Month 8	Advance costs as per contract		
		Develop broad talking points (refer to key messages, behavior change framework and action plan) for each talk show	Month 8	Internal: no cost		
		Disseminate information on program timings to the community	Month 9	Internal: no cost		
		Group discussions with communities after each talk show	Month 9 onwards	Travel costs, refreshments		
12	**Radio Spots**	Planning: number of spots, topics for each, selection of radio channels for airing, developing schedule for airing, coordination with approving body/committee	Month 8	Internal		
		Production of radio spots (identification of producer, developing scripts)	Month 9	Production costs for vendor		
		Airing as per finalized schedule	Month 10 onwards (as per schedule)	Airing costs for radio channel		
		Monitoring of spots during field visits	Month 10 onwards	Travel costs		

			(as per schedule)			
13	**Male foras (meet once a month or once in two months)**	Development of training module and plan for Male Foras	Month 7	Internal: no cost		
		Identification and training of Lead Fathers	Month 8	Training costs, travel costs		
		Male foras commence	Month 9 onwards (once a month)	Activity costs: incentives and refreshment		
14	**Community dialogues** on equal responsibilities of mothers and fathers on raising the child, including feeding, household chores and shared decision-making.	Develop plan: schedule, topics to be covered for each event (align with other activities), special guests to invite - religious leaders, community leaders, Medical staff etc.	Month 9	Internal: no cost		
		Orientation of field staff on conducting effective community dialogues (end with commitment and follow up through home visits)	Month 9	Training costs, travel costs		
		Conduct community dialogues	Month 10 onwards (once a month)	Activity costs: incentives and refreshment		
15	**Design and print SBCC materials** (Banners for cooking demonstrations, Recipe booklet, materials for male forums, e.g. picture cards on locally available nutritious food)	Review of existing materials (from other projects/organizations) based on key messages, bridges to activities in the strategy and using a checklist and develop list of materials to be produced	Month 7	Internal: no cost		

		Develop content for new materials	Month 7	Internal: no cost		
		Design and pre-test of materials	Month 8	Consultant cost for designing and pre-test		
		Finalize and print materials	Month 9	Printing costs		
Long Term: New Activities (Year 2)						
16	**Radio drama series**	Positive deviance inquiry to feed into storyline	Month 12	Research costs: IDIs, travel		
		Planning: identification of channel, costs, scriptwriter, producer, contracting formalities	Month 12	Internal: no cost		
		Development of a design document (content for messaging and storyline) - ideally through a workshop	Month 13	Workshop costs: venue, travel, equipment, stationery, refreshments (usually a 3 day workshop)		
		Pre-test of storyline	Month 13	Data collections costs: FGD, IDI, travel		
		Development of scripts	Month 14 onwards	Scriptwriter costs		
		Production of episodes	Month 14 onwards	Production costs for vendor		
		Airing of episodes	Month 15 onwards (based on schedule)	Airing costs for radio channel		
		Setting up listener clubs (MTMSGs, WASH committees, Fathers groups etc. and new groups)	Month 13	Local Travel costs		
		Training of Lead Mothers, Lead Fathers to facilitate listener groups	Month 14	Training costs, travel costs		
		Monitoring of episodes and listener group activities	Month 15 onwards	Travel costs		

17	**Campaign on advantages of the health facilities promoting the quality of services** (multi-channel - posters, radio spots etc.)	Develop plan for campaign (to time it around special days - e.g. World Health Day): details of activities, materials required, key messages, schedule, costs etc.	Month 14	Internal: no cost		
		Identify and engage a design agency to develop the creatives	Month 14	Advance costs as per contract		
		Sensitization of Health Workers and Health Providers (Doctors) on quality of care	Month 15	Training costs, travel costs		
		Development of draft creatives and pre-test	Month 15 and 16	Pre-test costs: materials, training, field work		
		Finalise materials and print/produce	Month 17	Printing/production costs		
		Roll out campaign as per schedule and monitor	Month 18	Airing costs for radio, distribution costs for other materials		
18	**Rapid Assessment** of activities implemented in year 1	Develop research design (qualitative) and plan	Month 13	Internal: no cost		
		Identify and engage external consultant/agency to conduct the assessment	Month 13	Consultant costs		
		Review SBCC strategy based on findings and modify as required (workshop)	Month 14	Workshop costs: venue, travel, equipment, stationery, refreshments (2 day workshop)		

Annexure I – SBCC Workshop Agenda

Agenda

Social and Behavior Change Strategy Development Workshop

March 30 and 31, 2021

Time: 9 am to 1 pm

Timing	Session	Method/Facilitation
Day 1, March 30, 2021		
9:00 - 9:20 am	Participant introductions and Objectives of the session	
9.20 - 9:30 am	Introduction to the SBC Strategy and Action Plan Development Process	Presentation and discussion
9:30 – 10:00 am	Formative research summary: Findings from desk review and FGDs with CHWs	Presentation and Q&A
10:00 - 10:40 am	Identification and prioritization of key behaviors	Prioritization exercise on a google doc
10:40 - 10:45 am	Break (if required)	
10:45 – 11:45 am	Defining Behavior Change Objectives	Presentation and group work
11:45 am – 1:00 pm	Introduction to the Behavior Change Framework: Identifying audiences, barriers and enablers for the prioritized behaviors	Small groupwork in breakout rooms
Day 2, March 31, 2021		
9:00 - 9:15 am	Recap of Day 1	
9:15 – 10:30 am	Behavior Change Framework: identifying bridges to behavior change and potential activities	Group work in breakout rooms
10.30 - 11:30 am	Key messages and activities	Presentation followed by group work
11:30 -11:35 am	Break	
11:35 - 12:55 pm	SBCC Action Plan Development	Presentation followed by group work
12:55 - 1:00 pm	Next steps and closing	

Annexure II – Prioritizing Behaviors Groupwork

Sl No.	Behaviors	How critical is this behavior to improve health/well-being among target groups? High/Med/Low	To what extent is it affecting program outcomes? High/Med/Low	Are most people not adopting this behavior currently?	What are the main determinants for this behavior?	Can the issue be addressed through SBCC?	Overall Level of Priority (High, Medium, Low)
1.	Mothers initiate breastfeeding within 1hour of birth	High	High	Yes	Social norms, Knowledge levels,	Yes	**High**
2.	Mothers exclusively breastfeed their babies from 0 – 6 months	High	High	Yes	Social norms, Knowledge levels, self efficacy	Yes	**High**
3.	Initiation of complementary feeding at 6 months	High	High	Yes	Self-efficacy, Social norms	Yes	**High**
4.	Parents/Caregivers feed the child (6 months onwards) in appropriate frequency, quality and quantity	High	High	Yes	Knowledge levels, Social norms, Perceived negative consequences	Yes	**High**
5.	Mothers/caregivers use a clean cup and spoon for feeding their child instead of bottle feeding	High	High	No	Knowledge levels, social norms	Yes	**Medium**
6.	Mothers continue breastfeeding along with complementary feeding at least till the child is 2 years old.	Medium (as compared to other behaviors - if child is fed in appropriate frequency, quality and quantity, this would be less critical)	High	Yes	Perceived negative consequences, social norms, gender norms	Yes	**Medium**
7.	Caregivers continue feeding in appropriate quantity, frequency even when the child is sick	High	High	Yes	Knowledge levels, social norms, perceived negative consequences	Yes	**High**
8.	Fathers are involved in feeding the child	High	High	Yes	Social norms, perceived negative consequences	Yes	**High**
9.	Parents/caregivers seek timely treatment when their child is sick	High	High	No	Perceived positive consequences, knowledge levels	Yes	**Medium**

Annexure III - Behavior Change Objectives Group Work

Objective 1 Mothers initiate breastfeeding within one hour of birth

Question	Answer
Who is the intended audience?	Mothers of newborn children
What is the action to be taken by the intended audience?	Initiate breastfeeding within the 1st hour of birth
How will this action contribute to the program goal?	Improving health/nutrition outcomes
In what timeframe will the behavior change occur? (state a beginning and end date)	3 years (2021-2023)
What is the amount of change that will be achieved in this timeframe? (state the current level and the desired objective)	Mothers will be initiating breastfeeding within the 1st hour of birth
Where will the change take place (program areas)	Binga, Kariba and Chimanimani districts

Summarize the objective: To increase the rates of initiation of breastfeeding within the 1st hour of birth from 60% to 75% in Chimanimani, Kariba and Binga districts by 2023/ Proportion of mothers who initiate breastfeeding within the 1st hour of birth increases from 60% to 75% in Chimanimani, Kariba and Binga districts by 2023

Objective 2

Question	Answer
Who is the intended audience?	Mothers with a child of 0-6 months
What is the action to be taken by the intended audience?	Mothers feed their babies only breastmilk for the first 6 months
How will this action contribute to the program goal?	It will help in the growth and development of the baby and prevent malnutrition, which is the program goal
In what timeframe will the behavior change occur? (state a beginning and end date)	3 years (2021 - 2023)
What is the amount of change that will be achieved in this timeframe? (state the current level and the desired objective)	From around 40% to
Where will the change take place (program areas)	Binga, Kariba and Chimanimani districts

Summarize the objective: Increase the proportion of Mothers feeding their children only breastmilk from birth to 6 months, from 40% to 60% in Binga Kariba and Chimanimani districts by 2023

Objective 3

Question	Answer
Who is the intended audience?	Parents/caregivers of children 6-23 months of age
What is the action to be taken by the intended audience?	Parents/caregivers feed their children in the recommended frequency, quality and quantity
How will this action contribute to the program goal?	Overall program goal is to contribute to reduction in mortality and morbidity due to malnutrition. The action will contribute to preventing malnutrition among children aged 6-23 months
In what timeframe will the behavior change occur? (state a beginning and end date)	3 years (2021-2023)
What is the amount of change that will be achieved in this timeframe? (state the current level and the desired objective)	MAD increases from 11 % to 30%
Where will the change take place (program areas)	Chimanimani, Kariba, Binga

Summarize the objective: The proportion of parents/caregivers feeding their child (6-23 months) in appropriate frequency, quality and quantity increases from 11% to 30% in Chimanimani, Binga and Kariba districts by 2023.

Annexure IV – Behavior Change Framework Groupwork

Behavior	Priority Group and Influencers	Barriers & Enablers - Key Determinants	Other Significant findings	Bridge to activities	Activities & Techniques
Mothers initiate breastfeeding within one hour of birth	Pregnant women, Mothers who have just given birth **Influencers:** Nurses, CHWs, Spouses, Grandmothers/mothers-in-law, religious leaders, TBAs	Belief that breast feeding in the first hour after birth is difficult because the mother will be in pain. A few mothers throw away colostrum saying its dirty milk and it makes the baby sick	Grandmothers/mothers-in-law, fathers and community members influence mothers in giving pre-lacteals	Increase perception that colustrum/first milk is healthy and boosts the child's immunity/ is healthy and beneficial for the child. Reduce perception that the mother will not be able to breastfeed within one hour of birth.	MTMSG weekly meetings - mothers who have practiced feeding within one hour of birth share their experience and the benefits. Health Worker Mentorship on a quarterly basis - include a special session around successes and challenges in initiating breastfeeding within an hour of birth. Mothers share experiences in group counseling sessions at facilities. (Health workers to be trained on conducting interactive sessions) IEC materials(posters, flyers etc.) - modified to suit the current context of COVID-19 (review the ones developed already)
Mothers exclusively breastfeed their babies from 0 – 6 months	Mothers of children (0-6 months) **Influencers:** Nurses, CHWs, Spouses, Grandmothers/mothers-in-law, religious leaders	Perceptions that the mother did not have sufficient milk especially when the child cries a lot, mothers felt it was because the milk would be inadequate for the child Belief that exclusive breastfeeding for 6 months is not good for a male child because by the time a child gets to three	The social acceptability - mothers in law and the general community encourage young mothers to practice mixed feeding	Increase perception that mother's milk is all that every baby, both girls and boys, 0-6 months need to be healthy, Increase perception that breast milk contains sufficient water as per the needs of a baby 0-6 months old, even in hot climate	MTMSG weekly meetings - mothers who have practiced EBF within share their experience and the benefits. Mothers share experiences in group counseling sessions at facilities. (Health workers to be trained on conducting interactive sessions) One on one counselling sessions for attachment and positioning (demonstrate proper positioning

		months the milk will no longer be enough.		Increase the perception that with correct positioning and attachment, every mother produces sufficient milk for her baby, regardless of the size of the breast	and attachment to the mother in a confidential setting)
Initiation of complementary feeding at 6 months	Caregivers (mothers, fathers, grandmothers, older siblings) **Influencers:** CHWs, religious leaders, Nurses/mid-wives, TBAs	Belief among mothers that a child needs more than milk to grow when they get to 3 months and the child always cries if you don't feed them food Poor quality complimentary foods emerging from a general prevalence of limited knowledge and information on good quality complimentary feeding. •This results in provision of bulky starches and relatively sub-standard foods.	In addition, both parents and caregivers are often not capacitated to leverage locally-available foods and existing family diets as means to improve complimentary feeding.	Increase capacity to leverage local available nutritious food Increase knowledge on good quality locally available food for a child (6 months and above)	Cooking demonstrations with parents, cooking competitions among MTMSG, Healthy baby competitions MTMSG weekly meetings - mothers/caregivers who have practiced initiating complementary feeding at 6 months share their experience and the benefits. Caregivers share experiences in group counseling sessions at facilities. Male foras (meet once a month or once in two months) discuss the locally available foods and how to ensure access - kitchen gardens, what is feasible for them to do to support the family.
Parents/Caregivers feed the child (6 months onwards) in appropriate frequency, quality and quantity	Caregivers (mothers, fathers, grandmothers, older siblings) **Influencers:** CHWs, religious leaders, Nurses/mid-wives, TBAs	•Children from households that had a home garden, consumed more vegetables than those who didn't have access to a home garden •Families with well nourished children gave a separate plate to the	Inadequate money to buy foods – unemployment and lack of income hinders mothers to feed children diverse diets. Perception that diverse foods	Increase perception that diverse food does not mean more food Increase perception that malnourishment can be prevented by feeding the child in adequate quantity, quality and	Tailormade lessons on the need for diverse food, age specific requirements for quality, quantity and frequency - lesson on healthy plate. Cooking demonstrations with parents focusing on quality and diversity of food; cooking competitions among MTMSG,

		child to eat and checked the quantity being eaten Mothers don't know if their children are susceptible to malnutrition Perceived negative consequences: Constipation Loss of appetite Child will choke Child eats less than he/she needs Damage to the child's gut You will feel bad for failing to care for your child	means more food, which leads to overfeeding and obesity. No decision making powers by mothers	frequency based on the child's age. Increase knowledge of the signs, symptoms and causes of malnutrition Increase knowledge on the age specific requirements for feeding the child (quality, quantity and frequency)	Healthy baby competitions
Mothers/caregivers use a clean cup and spoon for feeding their child instead of bottle feeding	Caregivers **Influencers:** CHWs, mid-wives, neighbours/friends	Bottle feeding seen as a status symbol. When mothers are busy, they can give the child a bottle and continue with their work. Bottle feeding is easier for the mother than using a cup and spoon. **Enabler:** Cup and spoon is easily available at home and there is no need to buy special utensils for the child Cup and spoon are easier to wash and clean	Mothers have high workload and very little support from the family on household chores	Increasing perception that feeding with a cup and spoon has more advantages than bottle feeding Increasing perception that mothers who use cup and spoon to feed the child, have healthier babies/care for the health of their child. Increase knowledge on the advantages and ease of use of cup and spoon for feeding the baby	Healthy baby competition, Demonstration on the use of cup and spoon to feed the child in MTMSGs and group sessions, sharing of experience by mother who is using cup and spoon on how easy it is and how it saves time,
Mothers continue breastfeeding along with	Mothers of children 0-23 months **Influencers**	Mothers believe that breastfeeding up to 24 months is difficult because	Traditionally boys are not supposed to be breastfeed up to	Increasing the perception that breastfeeding upto 2 years is not difficult	MTMSG, group counselling sessions - discuss, share experiences around feeding both

complementary feeding at least till the child is 2 years old.	Mother-in-laws, spouses, CHWs, Religious leaders	the child needs more milk and the mother loses weight. Most mothers wean their children before they reach 2 years citing that they cannot cope with house chores and going to the field and also breastfeed a child. Some mothers breastfeed for less than 2 years because they want to get pregnant with another child in that same period	2 years; it is believed they will be weak sexually. When a child is looking healthy there is no need to keep breastfeeding. Mothers leave home for work in the field, they don't have time to breastfeed the child.	and the mother will be able to produce the milk required for that age. Increase the perception that breastfeeding can continue while one is pregnant without harming the unborn child. Increase the perception that both boys and girls who are breastfed till two years, along with complementary feeding, are healthier/grow up to be healthier individuals	girls and boys for 2 years or more, can include fathers who may have been breastfed for 2 years or more to testify. Testimonials of fathers who have been breastfed for 2 or more years on radio spots,

Annexure V – SBCC Action Plan

Sl.	**Activities**	**Existing Program/Project and area (within which the activity will be implemented)**	**Integration with other sectors (specify the sector and integration platform/activity)**	**Timeline**	**Monitoring**	**Support**
I. Initiation of breastfeeding within one hour of birth						
1	MTMSG weekly meetings	In programs where Weekly meetings with mother to mother support group are ongoing	WASH (Water management committees to engage with the fathers), Health sector (Post natal visits, child's immunization)	Weekly meetings with the mother to mother support group	Weekly monitoring visits by the nutrition officers to the mother to mother support group meetings	Support from community leaders and the county health department
2	Health Worker Mentorship on a quarterly basis - include a special session around successes and challenges in initiating breastfeeding within an hour of birth	Ongoing activity, Community Nutrition/MIYCN Officer, at the facility level to support in developing the session	Explore integration with other sectors like health	Once in a quarter	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from MoH at all levels, UNICEF, and other actors on ground
3	Group counseling sessions at facilities.	Group counselling at OTP facilities, with the mother to mother support group, at GFD points, water points, mosque/common gathering places	Health sector (TBAs session with pregnant mothers, ANC at facility level , FSL (GFD and other components), Education (in school, teachers PTA meetings)	Daily at facility level (3 times), Once a month for MTMSG, GFD - depending on distribution once a month, PTA meetings on an average twice in a term (3 months)	Reporting system - report and pictures, audio or video clips, Technical person to visit once in quarter for monitoring, FGD at the community level	Atleast every facility should have an MIYCN counsellor (budgets for position, graduate Lead Mothers as Counsellors), regular refresher trainings of MTMSG, adequate compensation in kind to Lead Mothers

4	Health workers training on conducting interactive sessions	Community Nutrition/MIYCN Officer, at the facility level to train the health workers	Integration with training in health sector	Aligned with training of health workers, at least once in six months	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from MoH at all levels, UNICEF, and other actors on ground
5	Review of existing SBCC materials and modification or development of new materials	Review to include Mother to mother support group materials, MIYCN counselling cards, world breastfeeding week celebration materials, materials developed by MoH/other agencies	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
6	Radio Talk show	Some projects have been including but in limited numbers based on budget availability. It is a successful activity that needs to be increased in frequency	Explore with MoH for free air time for talk shows (mostly on COVID-19 these days)	At least once in a month, or in three phases during the year - series of 4 per month	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers
7	Training of Lead Mothers on the topic	Community Nutrition/MIYCN Officer, to train the Lead Mothers	Explore integration with other sectors like health	Once in six month's training (ideally it should be budgeted for quarterly basis)	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from MoH at all levels, UNICEF, and other actors on ground
II. Mothers feed their babies (0-6 months) only breast milk						
8	MTMSG weekly meetings	In programs where Weekly meetings with mother-to-mother support group are ongoing	WASH (Water management committees to engage with the fathers), Health sector (Post-natal visits, child's immunization)	Weekly meetings with the mother-to-mother support group	Weekly monitoring visits by the nutrition officers to the mother-to-mother support group meetings	Support from community leaders and the county health department

9	Group counseling sessions at facilities.	Group counselling at OTP facilities, with the mother to mother support group, at GFD points, water points, mosque/common gathering places	Health sector (TBAs session with pregnant mothers, ANC at facility level , FSL (GFD and other components), Education (in school, teachers PTA meetings)	Daily at facility level (3 times), Once a month for MTMSG, GFD - depending on distribution once a month, PTA meetings on an average twice in a term (3 months)	Reporting system - report and pictures, audio or video clips, Technical person to visit once in quarter for monitoring, FGD at the community level	Atleast every facility should have an MIYCN counsellor (budgets for position, graduate Lead Mothers as Counsellors), regular refresher trainings of MTMSG. adequate compensation in kind to the Lead Mothers
10	One on one counselling sessions for attachment and positioning	Facility based CNWs and MIYCN counsellers, outreach by the MIYCN counsellers, use of Community Nutrition Workers at the facility level, Community Nutrition Volunteers (CNVs) and mother to mother support group lead mothers	ANC visits (Health sector), include in trainings for mid-wives and doctors	Regularly during ANC visits (4 visits), on a weekly basis at the community level	Weekly monitoring visits by Nutrition Officers, Reviewing MIYCN Registers by Nutrition Officers	Support from Community Leaders at the community level, State MoH and CHD support for facility level
11	Develop and print reference guide for Health Worker	Review of any existing guide with MoH or other agencies. MIYCN Counsellor and Nutrition Technical Manager to support in developing the guide	Explore collaboration with health sector to modify any existing reference guide	Once, to be re-printed as per subsequent requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials

12	Review of existing SBCC materials and modification or development of new materials (Picture Story cards, posters, banners)	Review to include Mother to mother support group materials, MIYCN sounselling cards, printing of world brestfeeding week celebration materials, NIPP circles materials, materials developed by MoH/other agencies	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
13	Radio Talk show	Some projects have been including but in limited numbers based on budget availability. It is a successful activity that needs to be increased in frequency	Explore with MoH for free air time for talk shows (mostly on COVID-19 these days)	At least once in a month, or in three phases during the year - series of 4 per month	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers
14	Development of radio spots and airing	Some projects have been including but in limited numbers based on budget availability. It needs to be increased in frequency	Explore collaboration with other sectors to jointly approach radio channels for reduced costs for bulk airtime purchase	Can be planned in spurts - two weeks of 3-4 spots per day in a month for once in three months (depending on budget availibility)	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers
15	Developing and printing harmonized tally sheets for MTMSG	Existing tally sheets for MTMSG from different programs/regions and countries(?) to be reviewed	NA	Review and develop modified sheets in 2 months	Review of tally sheets being used by mothers, at weekly monitoring visits by the nutrition officers to the mother to mother support group meetings	Support from regional team in coordinating with different countries
III. Mothers initiate feeding their babies with solid/semi-solid foods at 6 months						

16	Cooking demonstrations with parents	Ongoing activity in programs, involve MTMSG members, also invite mothers who have issues/challenges, NIPP, encourage kitchen gardens	Integration with FSL (vegetable gardening, kitchen gardening)	Quarterly basis per MTMSG (depending on budget availability)	MIYCN counsellors visit homes during lunch time, Fix scheduled visits by CNVs or Nutrition oficers conduct home visits at times when mothers are cooking, Pictures/attendance/minutes compilation and analysis	Access to cooking demonstration manual and recipe book; Recruitment of staff with nutrition background or support from MIYCN technical person to train the available staff, exchange visits to other areas, adquate budgets for the activity
17	Cooking competitions among MTMSG,	New activity(?) , also invite mothers who have issues/challenges, NIPP, encourage kitchen gardens	Integration with FSL (vegetable gardening, kitchen gardening)	Quarterly basis per MTMSG (depending on budget availability)	MIYCN counsellors visit homes during lunch time, Fix scheduled visits by CNVs or Nutrition oficers conduct home visits at times when mothers are cooking, Pictures/attendance/minutes compilation and analysis	Access to cooking demonstration manual and recipe book; Recruitment of staff with nutrition background or support from MIYCN technical person to train the available staff, exchange visits to other areas, adquate budgets for the activity
18	Healthy baby competitions	New activity (?), involve MTMSG members, also invite mothers who have issues/challenges, NIPP, encourage kitchen gardens, babies whose mothers/parents have followed all/most recommended behaviors and are well nourished	Integration with FSL (vegetable gardening, kitchen gardening) or health (to include vaccinations)	Quarterly basis per MTMSG (depending on budget availability)	MIYCN counsellors visit homes during lunch time, Fix scheduled visits by CNVs or Nutrition oficers conduct home visits at times when mothers are cooking, Pictures/attendance/minutes compilation and analysis	Support from community leaders and MoH at various levels to organize the activity
19	MTMSG weekly meetings	In programs where Weekly meetings with mother to mother support group are ongoing	WASH (Water management committees to engage with the fathers), Health sector (Post natal visits, child's immunization)	Weekly meetings with the mother to mother support group	Weekly monitoring visits by the nutrition officers to the mother to mother support group meetings	Support from community leaders and the county health department

20	group counseling sessions at facilities.	Group counselling at OTP facilities, with the mother to mother support group, at GFD points, water points, mosque/common gathering places	Health sector (TBAs session with pregnant mothers, ANC at facility level , FSL (GFD and other components), Education (in school, teachers PTA meetings)	Daily at facility level (3 times), Once a month for MTMSG, GFD - depending on distribution once a month, PTA meetings on an average twice in a term (3 months)	Reporting system - report and pictures, audio or video clips, Technical person to visit once in quarter for monitoring, FGD at the community level	Atleast every facility should have an MIYCN counsellor (budgets for position, graduate Lead Mothers as Counsellors), regular refresher trainings of MTMSG. adequate compensation in kind to the Lead Mothers
21	Male foras (meet once a month or once in two months)	New activity, Review other similar programs to learn from (e.g. Real Fathers - Save The Children, Uganda)	WASH (Distribution of NFI), GFD,	Monthly	Regular program monitoring by the MICYN technical manager	Permission from local stakeholders/community leaders, UNICEF technical support on training
22	Design and print SBCC materials (Banners for cooking demonstrations, Healthy Baby Competitions Recipe booklet for complementary feeding, Specific materials for male forums, e.g. picture cards on locally available nutritious food)	Review to include Mother to mother support group materials, MIYCN sounselling cards, printing of world brestfeeding week celebration materials, NIPP circles materials, materials developed by MoH/other agencies	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
IV. Parents/Caregivers feed the child (6 months onwards) in appropriate frequency, quality and quantity						
23	MTMSG weekly meetings	In programs where Weekly meetings with mother-to-mother support group are ongoing	WASH (Water management committees to engage with the fathers), Health sector (Post natal visits, child's immunization)	Weekly meetings with the mother-to-mother support group	Weekly monitoring visits by the nutrition officers to the mother-to-mother support group meetings	Support from community leaders and the county health department

24	Training of Lead Mothers on tailormade lessons on the need for diverse food, age specific requirements for quality, quantity and frequency - lesson on healthy plate.	Community Nutrition/MIYCN Officer, to train the Lead Mothers	Explore integration with other sectors like health	Once in six month's training (ideally it should be budgeted for quarterly basis)	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from MoH at all levels, UNICEF, and other actors on ground
25	Cooking demonstrations with parents focusing on quality and diversity of food;	Ongoing activity in programs, involve MTMSG members, also invite mothers who have issues/challenges, NIPP, encourage kitchen gardens	Integration with FSL (vegetable gardening, kitchen gardening)	Quarterly basis per MTMSG (depending on budget availability)	MIYCN counsellors visit homes during lunch time, Fix scheduled visits by CNVs or Nutrition oficers conduct home visits at times when mothers are cooking, Pictures/attendance/minutes compilation and analysis	Access to cooking demonstration manual and recipe book; Recruitment of staff with nutrition background or support from MIYCN technical person to train the available staff, exchange visits to other areas,
26	Healthy baby competitions	New activity(?) , also invite mothers who have issues/challenges, NIPP, encourage kitchen gardens	Integration with FSL (vegetable gardening, kitchen gardening)	Quarterly basis per MTMSG (depending on budget availability)	MIYCN counsellors visit homes during lunch time, Fix scheduled visits by CNVs or Nutrition oficers conduct home visits at times when mothers are cooking, Pictures/attendance/minutes compilation and analysis	Access to cooking demonstration manual and recipe book; Recruitment of staff with nutrition background or support from MIYCN technical person to train the available staff, exchange visits to other areas,
27	Cooking competitions among MTMSG	New activity (?), involve MTMSG members, also invite mothers who have issues/challenges, NIPP, encourage kitchen gardens, babies whose mothers/parents have followed all/most recommended behaviors and are well nourished	Integration with FSL (vegetable gardening, kitchen gardening) or health (to include vaccinations)	Quarterly basis per MTMSG (depending on budget availability)	MIYCN counsellors visit homes during lunch time, Fix scheduled visits by CNVs or Nutrition oficers conduct home visits at times when mothers are cooking, Pictures/attendance/minutes compilation and analysis	Support from community leaders and MoH at various levels to organize the activity

28	Review of existing SBCC materials and modification or development of new materials (Picture Story cards, posters, banners, lessons for MTMSG etc.)	Review to include Mother to mother support group materials, MIYCN sounselling cards, printing of world brestfeeding week celebration materials, NIPP circles materials	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
29	Radio Talk show	Some projects have been including but in limited numbers based on budget availability. It is a successful activity that needs to be increased in frequency	Explore with MoH for free air time for talk shows (mostly on COVID-19 these days)	At least once in a month, or in three phases during the year - series of 4 per month	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers
25	Development of radio spots and airing (testimonials of positive deviant parents)	Some projects have been including but in limited numbers based on budget availability. It needs to be increased in frequency	Explore collaboration with other sectors to jointly approach radio channels for reduced costs for bulk airtime purchase	Can be planned in spurts - two weeks of 3-4 spots per day in a month for once in three months (depending on budget availibility)	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers
V. Mothers/caregivers use a clean cup and spoon for feeding their child instead of bottle feeding						

30	Healthy baby competition,	New activity(?) , also invite mothers who have issues/challenges, NIPP, encourage kitchen gardens	Integration with FSL (vegetable gardening, kitchen gardening)	Quarterly basis per MTMSG (depending on budget availability)	MIYCN counsellors visit homes during lunch time, Fix scheduled visits by CNVs or Nutrition oficers conduct home visits at times when mothers are cooking, Pictures/attendance/minutes compilation and analysis	Access to cooking demonstration manual and recipe book; Recruitment of staff with nutrition background or support from MIYCN technical person to train the available staff, exchange visits to other areas, adequate budgets for the activity
31	MTMSG weekly meetings	In programs where Weekly meetings with mother-to-mother support group are ongoing	WASH (Water management committees to engage with the fathers), Health sector (Post-natal visits, child's immunization)	Weekly meetings with the mother-to-mother support group	Weekly monitoring visits by the nutrition officers to the mother-to-mother support group meetings	Support from community leaders and the county health department
32	Group counseling sessions at facilities.	Group counselling at OTP facilities, with the mother-to-mother support group, at GFD points, water points, mosque/common gathering places	Health sector (TBAs session with pregnant mothers, ANC at facility level , FSL (GFD and other components), Education (in school, teachers PTA meetings)	Daily at facility level (3 times), Once a month for MTMSG, GFD - once a month, PTA meetings on an average twice in a term	Reporting system - report and pictures, audio or video clips, Technical person to visit once in quarter for monitoring, FGD at the community level	Every facility should have an MIYCN counsellor (budgets for position, graduate Lead Mothers as Counsellors), regular refresher trainings of MTMSG. adequate compensation in kind to Lead Mothers
33	Review of existing SBCC materials and modification or development of new materials (Picture Story cards, posters, banners, lessons for MTMSG, branded cups and spoons etc.)	Review to include Mother to mother support group materials, MIYCN sounselling cards, printing of world brestfeeding week celebration materials, NIPP circles materials, materials developed by MoH/other agencies	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
VI. Mothers continue breastfeeding along with complementary feeding at least till the child is 2 years old.						

34	MTMSG weekly meetings	In programs where Weekly meetings with mother to mother support group are ongoing	WASH (Water management committees to engage with the fathers), Health sector (Post natal visits, child's immunization)	Weekly meetings with the mother to mother support group	Weekly monitoring visits by the nutrition officers to the mother to mother support group meetings	Support from community leaders and the county health department
35	Group Counselling sessions at facilities	Group counselling at OTP facilities, with the mother to mother support group, at GFD points, water points, mosque/common gathering places	Health sector (TBAs session with pregnant mothers, ANC at facility level , FSL (GFD and other components), Education (in school, teachers PTA meetings)	Daily at facility level (3 times), Once a month for MTMSG, GFD - depending on distribution once a month, PTA meetings on an average twice in a term (3 months)	Reporting system - report and pictures, audio or video clips, Technical person to visit once in quarter for monitoring, FGD at the community level	Atleast every facility should have an MIYCN counsellor (budgets for position, graduate Lead Mothers as Counsellors), regular refresher trainings of MTMSG. adequate compensation in kind to the Lead Mothers
36	Development of radio spots - Testimonials of fathers who have been breastfed for 2 or more years	Some projects have been including but in limited numbers based on budget availability. It needs to be increased in frequency	Explore collaboration with other sectors to jointly approach radio channels for reduced costs for bulk airtime purchase	Can be planned in spurts - two weeks of 3-4 spots per day in a month for once in three months (depending on budget availability)	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers
37	Radio talk show	Some projects have been including but in limited numbers based on budget availability. It is a successful activity that needs to be increased in frequency	Explore with MoH for free air time for talk shows (mostly on COVID-19 these days)	At least once in a month, or in three phases during the year - series of 4 per month	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers

38	Review of existing SBCC materials and modification or development of new materials (Counselling cards, posters, banners, etc.)	Review to include Mother to mother support group materials, MIYCN sounselling cards, printing of world brestfeeding week celebration materials, NIPP circles materials	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
VII. Caregivers continue feeding in appropriate quantity and frequency even when the child is sick						
39	Group counselling, - sharing experiences on how to feed/care for their child when they are sick, including Demonstration session on how to prepare home remedies.	Group counselling at OTP facilities, with the mother to mother support group, at GFD points, water points, mosque/common gathering places	Health sector (TBAs session with pregnant mothers, ANC at facility level , FSL (GFD and other components), Education (in school, teachers PTA meetings)	Daily at facility level (3 times), Once a month for MTMSG, GFD - depending on distribution once a month, PTA meetings on an average twice in a term	Reporting system - report and pictures, audio or video clips, Technical person to visit once in quarter for monitoring, FGD at the community level	Atleast every facility should have an MIYCN counsellor (budgets for position, graduate Lead Mothers as Counsellors), regular refresher trainings of MTMSG. adequate compensation in kind to the Lead Mothers
40	MTMSG weekly meetings	In programs where Weekly meetings with mother to mother support group are ongoing	WASH (Water management committees to engage with the fathers), Health sector (Post natal visits, child's immunization)	Weekly meetings with the mother to mother support group	Weekly monitoring visits by the nutrition officers to the mother to mother support group meetings	Support from community leaders and the county health department
41	Radio talk show	Some projects have been including but in limited numbers based on budget availability. It is a successful activity that needs to be increased in frequency	Explore with MoH for free air time for talk shows (mostly on COVID-19 these days)	At least once in a month, or in three phases during the year - series of 4 per month	Assigning field staff to listen to recorded messages being aired as per schedule. Monitoring on site with the recording of the data - asking community if they have heard. Including community feedback in ongoing monitoring/KAP surveys/FGDs etc.	Support from MoH on the airtime, approval from authorities to organize the talk show (approving committee), support from internal media and communication team, radio sets for Lead mothers

42	Review of existing SBCC materials and modification or development of new materials (Picture story cards, leaflets etc.)	Review to include Mother to mother support group materials, MIYCN sounselling cards, printing of world brestfeeding week celebration materials, NIPP circles materials	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
VIII. Fathers are involved in feeding the child						
43	Male foras (meet once a month or once in two months)	New activity, Review other similar programs to learn from (e.g. Real Fathers - Save The Children, Uganda)	WASH (Distribution of NFI), GFD,	Monthly	Regular program monitoring by the MICYN technical manager	Permission from local stakeholders/community leaders, UNICEF technical support on training
44	Community dialogue on equal responsibilities of mothers and fathers on raising the child, eeding, household chores and shared decision-making.	To include this topic (gender issues) in ongoing community dialogues in programmes	Collaboration with GBV/protection sector for key messages and activities	Once in two months	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from community leaders, MoH at different levels
45	Training of Lead Fathers on IYCN and to hold individual and group sessions with fathers	Community Nutrition/MIYCN Officer, to train the Lead Fathers	Explore integration with other sectors like health	Once in six month's training (ideally it should be budgeted for quarterly basis)	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from MoH at all levels, UNICEF, and other actors on ground
46	Testimonials from fathers shared in MTMSG, Lead Fathers taking sessions with MTMSG.	Invite positive deviant fathers to some of the Weekly MTMSG meetings or invite a group of fathers to attend an MTMSG meeting on this topic	WASH (Water management committees to engage with the fathers)	Once a month/once in 3 months	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from community leaders

47	Design and print SBCC materials (Specific materials for male forums, e.g. banners, picture cards on locally available nutritious food)	Review to include Mother to mother support group materials, MIYCN sounselling cards, printing of world brestfeeding week celebration materials, NIPP circles materials, materials developed by MoH/other agencies	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials
IX. Parents/caregivers seek timely treatment when their child is sick						
48	Community dialogue facilitated by Health providers	To include this topic (gender issues) in ongoing community dialogues in programmes and invite Health Providers as special guests	Collaboration with health sector for participation in the activity	Once in two months	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from community leaders, MoH at different levels
49	Campaign on advantages of the health facilities promoting the quality of services (multi-channel - posters, radio spots etc.)	New activity, could be organized around special days such as World Health Day	Collaboration with Health sector in planning and support	Once in a year/once in six months	Intensive monitoring during the campaign by Officcers and coordinators	Support from MoH
50	Male foras (meet once a month or once in two months) discuss the importance of seeking timely treatment.	New activity, Review other similar programs to learn from (e.g. Real Fathers - Save The Children, Uganda)	WASH (Distribution of NFI), GFD,	Monthly	Regular program monitoring by the MICYN technical manager	Permission from local stakeholders/community leaders, UNICEF technical support on training
51	Training of Lead Fathers on IYCN and to hold individual and group sessions with fathers	Community Nutrition/MIYCN Officer, to train the Lead Fathers	Explore integration with other sectors like health	Once in six month's training (ideally it should be budgeted for quarterly basis)	Regular program monitoring Nutrition Coordinators/Nutrition Managers, at least two visits per year by the MICYN technical manager	Support from MoH at all levels, UNICEF, and other actors on ground

52	Group counselling session at health facility to include this topic - motivate them to share their experience with others in the community.	Group counselling at OTP facilities, with the mother to mother support group, at GFD points, water points, mosque/common gathering places	Health sector (TBAs session with pregnant mothers, ANC at facility level , FSL (GFD and other components), Education (in school, teachers PTA meetings)	Daily at facility level (3 times), Once a month for MTMSG, GFD - once a month, PTA meetings on an average twice in a term	Reporting system - report and pictures, audio or video clips, Technical person to visit once in quarter for monitoring, FGD at the community level	Atleast every facility should have an MIYCN counsellor (budgets for position, graduate Lead Mothers as Counsellors), regular refresher trainings of MTMSG. adequate compensation in kind to the Lead Mothers
53	Review of existing SBCC materials and modification or development of new materials (Picture story cards, leaflets etc.)	Review to include Mother to mother support group materials, MIYCN sounselling cards, world brestfeeding week celebration materials, NIPP circles materials, materials developed by MoH/other agencies	Media and communications department (branding as well as disseminating through social media, radio talk show etc.)	Based on project specific requirement	Regular review of materials to be printed by the Nutrition technical person in collaboration with the Media and Communications team. Nutrition technical person also monitors appropriate utilization of the materials	Support from MoH for review and approvals and from local partners for inputs during development of materials